Attachment 1

Mental Health/Alcohol and Other Drug Abuse Managed Care

Request for Consideration

Questions, Answers and Additional Information for Proposers

March 23, 2000

PART A: INTRODUCTION

This document contains questions about the Mental Health/Alcohol and Other Drug Abuse (MH/AODA) Managed Care Request for Consideration (RFC) and responses to those questions. These include questions that were raised at the March 1st Proposers Conference, in addition to questions directly communicated to the Department of Health and Family Services.

In addition, this document contains important new information about resources available, additional requirements to obtain these resources, and changes in instructions about submitting your proposal. As such, this document constitutes an amendment to the RFC, as allowed under Section VII.H. of the RFC. Failure to comply with these additional requirements and changes may be a basis for a proposal being eliminated from consideration as noted in Section IX. C. of the RFC.

The responses in this document constitute the DHFS's official response to the questions and supercede verbal communication provided during the Proposers Conference or through direct communication. Any discrepancies between prior verbal or written communication and the responses contained in this document are presumed to be resolved in favor of the responses in this document.

PART B: NEW INFORMATION FOR PROPOSERS

The following additions and changes are organized according to the section of the RFC that they reference.

Section III. Overview of the Proposal and Program Requirements

1. Relationship to Existing Medicaid Managed Care Programs

Sec. III. B. 7. b. (p. 18) states that if a county is operating a Medicaid managed care program for children with severe emotional disturbance (SED) and the county is proposing to include children in their MH/AODA managed care demonstrations, the SED program must be consolidated into MH/AODA managed care. The DHFS now amends that statement as follows: if a county is operating a Medicaid managed care program for children with severe emotional disturbance (SED) and the county is submitting a proposal for MH/AODA managed care, the county must incorporate the SED program into MH/AODA managed care. That is, even if a county is proposing a MH/AODA managed care demonstration that does not initially include children, the

SED program needs to be incorporated into MH/AODA managed care. The exact timeline for this to happen will be negotiated individually with each site. The DHFS does not anticipate that demonstration sites will be required to undertake this process during the first year of capitation for MH/AODA managed care (currently projected for calendar year 2002).

The rationale for this is that each separate managed care program requires considerable administrative resources for the DHFS (and for the county as well). The existence of two such programs in one county (or one multi-county site) leads to inefficiencies in our administration of the programs. It may also lead to confusion among consumers.

This does not imply that the DHFS will pay only one capitation rate for all enrolled individuals. Depending upon the actuarial analysis, it is possible that we will pay a different capitation rate for children and adolescents than for adults.

2. Including All Age Groups in the Demonstration Projects

Those sites that do not have other specialty mental health/alcohol and other drug abuse managed care programs will not be required to include all age groups into MH/AODA managed care during the demonstration phase. The demonstration phase is defined as phases 1-3 of the table in Attachment 28 (p. 184). However, as noted in Section III. A. 5. a., and in the table on pp. 83-84, additional points will be given to sites including all age groups. Any sites not including all ages for the demonstration phase will be required to work with the DHFS during phase 3 (CY 04-05) to plan for how to incorporate all age groups into the demonstrations in phase 5.

3. Recovery Training

Section III. F. 5 of the RFC requires the MCO to provide or arrange for recovery training for all individuals providing services under this contract. As noted, the DHFS will develop the core training modules. However, the DHFS will also arrange and pay for the recovery training for the staff of the demonstration sites. The MCO will need only make their staff available for the trainings.

Section IV. Resource Available

4. Substance Abuse Block Grant Funds

Thirty thousand dollars ($30,000) is available in one-time only substance abuse block grant (SABG) funding for training and technical assistance, addressing substance abuse issues and client advocacy training for participants (women/children) served by the MH/AODA managed care demonstrations. The $30,000 is the amount available for all four sites, but will be allocated based upon the budgets included in the proposal.

Each site can use the SABG funding to pay for the participation of consumers in grant oversight committees and advocacy efforts focused upon substance abuse treatment.

This can be in the area of stigma reduction and use of gender/culture appropriate treatment programming. Funds can also be used for the development of dual diagnosis services as described in Sec. III. D. 5. 1 of the RFC. It cannot be used for any form of lobbying.

Proposers should identify in their budgets for which activities these funds will be utilized. Allowable costs must be incurred by September 30, 2000.

Section VII. Procurement Process

5. Change in Contact Person

Beginning March 30, 2000, the contact person for questions about the RFC or for requests for reasonable accommodations is:

Therese Ahlers, Chief
Systems Design and Monitoring Section
Bureau of Community Mental Health, Rm. 433
P.O. Box 7851
Madison, WI 53707-7851

Phone: 608-266-9330
Fax: 608-267-7793
Email: ahlertm@dhfs.state.wi.us

6. Change in Where to Submit Your Proposal

Section VII. I (p. 67) is amended to read:

The items noted above are to be submitted to:

Therese Ahlers, Chief
Systems Design and Monitoring Unit
Bureau of Community Mental Health
1 West Wilson Street, Rm. 433
P.O. Box 7851
Madison, WI 53707-7851

The submission date remains May 1, 2000, 4:30 p.m. (CDT).

7. Formatting Your Proposal

In addition to using 12 pt. type for your proposal, please double space and use margins (on all four sides) of no less than 1 inch. Because there are "targets" for response length as opposed to absolute page limits, proposers do not need to use layout "tricks" to fit their response into a limit.

Proposers are reminded that good organization of your proposal can effect your final score: if evaluators cannot find necessary material, you will not receive the full credit you may otherwise be eligible to receive. If you wish to reference information previously provided in another answer, please be very specific so that a reviewer can easily find the information (e.g., we previously described our consumer satisfaction survey in our response to I. 11.).

Section VIII. Program Narrative

8. Percentage of Staff Time Devoted to the Project

Attachment 32 (p. 188), *Personnel of the Demonstration Project*, asks proposers to identify the percentage of time for the various personnel of the demonstration. In the case of agency personnel who will have responsibilities for other projects, this number should reflect the percentage of time dedicated to the MH/AODA managed care project. Please note in your narrative response to this question whether you anticipate hiring new personnel specifically for this project.

9. Proposal Scoring

The table on pp. 83-84 of the RFC incorrectly identifies the total possible score for section L., Commitment and Support, as 10. This should read 15. The total points available, 500, then agree with the sum of the sections.

10. Expansion

During the process of evaluating the proposals in response to this RFC, the evaluation team will identify all proposals that meet minimum criteria for participation in the demonstrations. Should more than four sites submit acceptable proposals, the sites that are not chosen for funding in this biennium will have the first opportunity to participate in the demonstration should the Legislature authorize additional sites in the 2001-2003 biennial budget. The DHFS does not intend to conduct a separate procurement for additional sites unless the Legislature authorizes expansion to more sites than those for which we have acceptable proposals in response to this RFC.

11. Letters of Intent Received

As of March 9th, the due date for letters of intent to submit proposals, the DHFS had received letters of intent from the following sites:

- Dane County
- Forest/Vilas/Oneida Counties
- Kenosha County
- Milwaukee County

- Racine County

Submission of a letter of intent does not obligate a site to submit a proposal. Also, counties/tribes were not required to submit a letter of intent in order to respond to the RFC. Other counties/tribes who did not submit a letter of intent may still submit a proposal, if they wish to do so.

PART C: QUESTIONS AND ANSWERS

The following questions and answers are organized according to the section of the RFC that they reference.

Section III.

1. There are a lot of requirements in this section and relatively little money to implement them. Does the DHFS really expect us to do all of this?

The requirements in Section III. of the RFC represent the planning group's effort to "flesh-out" the vision of the final report of the Governor's Blue Ribbon Commission on Mental Health. We understand that not every proposer will be able to do everything, at least in the short run. We ask only that you submit a proposal that reflects your best response as to what you can do in the timeframes identified. As noted above, the DHFS is making additional funds available from the mental health and substance abuse block grants.

2. Can counties collect data on a sample of persons in the non-capitated population rather than all?

Sec. III. A. 1. (p. 12) requires successful proposers to develop information systems capable of tracking service utilization and costs across all programs (both capitated and non-capitated components of the demonstrations). The rationale for asking counties/tribes to collect this data for persons in the non-capitated component of the demonstrations is to support future development of the capitated component. That is, in order to move more persons into capitated managed care we need to be able to more accurately analyze their utilization and cost patterns. Additionally, we potentially want to use this information to support a Medicaid eligibility waiver request to expand Medicaid eligibility to certain populations as described in Sec. III. A. 4 of the RFC. The appropriateness of sampling, then, is tied to these goals.

The required data analysis for either of these efforts is dictated, to a large degree, by the requirements of our actuaries. In general, our actuaries prefer to work with data on the entire eligible population. In lieu of this, the size of the desired database tends to be measured in thousands of individuals rather than hundreds. As a result, the use of sampling will probably be precluded in all but the largest counties.

Proposers may propose a sampling technique for the ongoing data collection for individuals in the non-capitated component. However, the DHFS will not be able to commit to any such sampling plan until DHFS staff, in consultation with our actuaries, has reviewed this.

Proposers should note that the data collection for the non-capitated component is limited to consumers served by the 51 system. The DHFS does not expect the demonstration sites to identify potential eligibles who may not currently be served by the 51 system and collect information on these individuals.

3. **Section III. A. 3 (p. 14) notes that the DHFS is interested in proposals for carve-in programs. We have found that our primary care HMO partner is reluctant to partner with us at this time, because of concerns about the AFDC and BadgerCare rates. What can you tell us about what is happening in this area?**

A number of HMOs have expressed concerns about the adequacy of the rate offer in the 2000-2001 contract. In response to those concerns, the Department amended the offer for BadgerCare. Instead of an 8% rate increase with risk sharing of $10.4 million, we are offering HMOs a choice of one of the following options:

- A 12% rate increase for BadgerCare and no risk sharing; or
- An 8% rate increase for BadgerCare and risk sharing of up to $14.5 million.

Both options assume rates retroactive to July 1, 1999 through December 31, 2000, for BadgerCare. Risk sharing for BadgerCare is retroactive to July 1, 1999 through June 30, 2001. An additional 3% is budgeted in Act 9 for AFDC, Healthy Start, and BadgerCare rates for calendar year 2001.

4. **Do the front-end enhancements described in Section III. C. (p. 18) apply only to target population 1 and 2? What is the baseline measurement for consumer access and participation?**

The front-end enhancements apply to anyone first needing or wanting to access services or information about services. Therefore, these would potentially effect all target population members who come in contact with the county/tribal human services system.

Proposers should define how they would propose to measure access and participation. Once we have selected the demonstration sites, we will explore the similarities in approaches proposed to determine whether we can develop some common measures across sites.

5. Why is it that the MH/AODA managed care demonstrations do not appear to need to address the "firewall" issues between screening and care management organization that Family Care has needed to address?

During the planning process, the DHFS accepted the recommendation of our planning group not to mandate the creation of separate resource centers for MH/AODA managed care. Instead, counties/tribes would incorporate the screening process into their current intake procedures. However, an independent enrollment broker under contract to the DHFS will review the screens once completed. This independent broker will make the determination about whether, based on the screen, the individual is eligible for enrollment into MH/AODA managed care. We are able to use an independent entity in this way because the screen is not also determining eligibility for Medicaid.

This then provides the separation between the screening process and the managed care organization about which HCFA has had concerns in Family Care. Additionally, the enrollment broker will conduct random book-behinds to verify that the screens submitted to them accurately reflect the status of the individual applying for enrollment.

6. Currently, Medicaid does not reimburse services for individuals ages 21-64 residing in Institutions for Mental Disease (IMDs). Under managed care is it possible for the MCO to use the capitation dollars to pay for services for this age group in IMDs? If so, doesn't this contradict the statement that you must use Medicaid-certified providers for Medicaid-covered services?

Yes, capitated Medicaid dollars can be used to pay for services provided to individuals 21-64 in IMDs. This is because the MCO can use capitated Medicaid funds more flexibly than under the fee-for-service system. This is allowed as long as the recipient's needs can be met with the alternative service.

When an MCO uses a non-Medicaid-covered service, then the provider is not required to be a Medicaid-certified provider for that service. However, the provider must meet any applicable certification or licensure requirements for the service they are providing.

However, most IMDs are Medicaid-certified because they are a Medicaid-covered service for children and adolescents (up through age 20) and for individuals 65 and older.

7. Why can't the DHFS collect cost information on people in IMDs and build this into the capitation rate?

Federal Medicaid regulations require that the Medicaid capitation rate be based on what it would cost *Medicaid* to provide services to the target population in absence of the managed care program. Since IMDs are not covered for individuals age 21-64 in the fee-for-service Medicaid system, this cost will be zero.

The DHFS does want to identify the costs counties/tribes incur for individuals in IMDs for purposes of calculating the community aids, county match and county overmatch currently supporting services for the target population.

8. The RFC says in Section III. D. 5. e. (p. 27-28) that the MCO does not need to make every Category B service available to every individual as long as it can provide services sufficient to meet the consumer's needs. However, later (in Section III. D.5.h.) the RFC says that the MCO does need to make any Category B service available if ordered by the court (with certain exceptions). This seems like a discrepancy.

This language was developed for use in the Medicaid AFDC/Healthy Start HMO contracts to limit the HMO's liability for paying for providers outside their network. In some cases, juvenile court judges chose to order a particular provider to conduct a psychological evaluation of a child. The DHFS determined that the HMO should not have to pay an out-of-network provider if the HMO could have provided this service with a provider in their network.

It is most typical under Chapter 51 that the courts commit individuals to the care of the human services board rather than order specific services (except that the consumer may be committed to inpatient care or medications). Counties then are liable for the costs of whatever care they determine is necessary to meet the individual's needs. As noted at the end of Sec. III. D. 3. c.(6), nothing in the RFC alters current statutes or polices related to involuntary actions, nor does the DHFS anticipate that the courts will change the manner in which they resolve commitment hearings. Therefore, we do not anticipate that the liability to counties for Category B services will change as a result of the demonstrations.

Additionally, the DHFS anticipates that some of these issues will be resolved through the Treatment and Recovery Team process. We will be providing technical assistance to the demonstration sites on the protocols that other programs (e.g., Family Care, WrapAround Milwaukee) have developed for making decisions about services.

9. The RFC states in Sec. III. H .2.b. (p. 45) that the MCOs must conform with HIPAA requirements. Must the DHFS conform with HIPAA requirements as well? Specifically, will the DHFS limit reporting to the established national data set?

All health plans must comply with the HIPAA rules. This includes the Wisconsin Medicaid program. Among other things, HIPAA requires the standardized use of national reporting codes. Therefore, DHFS will use these for MH/AODA managed care reporting. However, until the final rule is published (currently projected for late spring or early summer of 2000), we do not know if and where the exceptions to the use of national codes will be.

10. Section III. H. 2. (pp. 44-46) discusses reporting requirements. Who is developing the reporting requirements and the standards for how the resulting data will be analyzed?

Some work on reporting requirements was done by our planning partners (see Attachment 21 of the RFC, for example). We will also build on current Medicaid reporting requirements, such as the encounter data identified in Attachment 22. An internal DHFS workgroup will continue to develop recommendations for reporting and bring these to the demonstration sites for review.

Through our planning, we have tried to be cognizant of current county/tribal reporting requirements and build on these, rather than create new data requirements. The internal DHFS workgroup has been looking at reporting requirements across initiatives (e.g., Family Care; WiSACWIS) to attempt to coordinate reporting expectations.

11. What sorts of information systems are available to help us meet the requirements in Sec. III. H. 2?

Technical assistance regarding information systems will be one of the first priorities as we begin working with the successful proposers. This will include reviewing the reporting requirements and the reporting process, identifying the information system needs, and exploring the adequacy of various systems to meet these needs.

Attached is a list of websites for various information systems that we have identified over the planning period. Likely, other products are available as well. The DHFS does not endorse any particular product.

Section IV.

12. Can a proposer propose to use all the start-up funds for management information system development?

No. The DHFS did not anticipate that the available start-up funds would cover the total costs of information system changes. There are many development activities that the counties/tribes must engage in, and we want to see the funds spread across these.

Sites may propose to use up to $100,000 of the start-up funds for information systems development. However, the DHFS will also work with demonstration sites to explore how to meet information system needs. For instance, in Family Care the DHFS helped arrange for the pilot sites to obtain, at no cost, the care management software developed for the Wisconsin Partnership Program.

13. It does not seem fair to larger counties that they will receive the same level of start-up funds as smaller counties. Is it possible to have an allocation of funds proportional to the size of the project?

The DHFS feels that the start-up funds allocated in the budget are the minimum that each site should receive. This amount is currently identified as $160,000; but, as noted in Sec. IV of the RFC, the DHFS continues to explore with HCFA whether we can increase this amount by more effectively matching federal Medicaid funds.

However, the DHFS expects to allocate the mental health and substance abuse block grant funds according to the merits of each proposal. Therefore, while $500,000 is available per year from the mental health block grant, this will not necessarily be allocated evenly across the successful demonstration sites. A proposal that requests more than one quarter of this amount and better meets the requirements for the funds (which will be communicated in a follow-up memo in approximately one week) may receive this larger amount of funding.

The DHFS recognizes that the amount of funds available for start-up and development of the managed care programs needs to be increased for <u>all</u> of the demonstration sites, and we are committed to continue to explore ways to achieve this.

<u>Section V</u>

14. Will the Medicaid capitation rate be based on the results of the functional screen or on actual utilization of services?

The functional screen will be used to determine only whether someone is eligible for enrollment or not. We have not developed the screen to yield levels of functional disability that would affect the capitation rate. This is different from the Family Care functional screen.

The capitation rate or rates will be based on the rate-setting process we engage in during the 18-month development period, as described in Section V. A. (p. 53). Taking individuals identified through the screen, we will identify their *historical* Medicaid costs and use these to project their future Medicaid costs. We can also incorporate the costs these individuals incur during the development period prior to when capitation begins.

As noted in Section V. B. (p. 56) of the RFC, we may develop different capitation rates based on age, gender or Medicare dual eligibility, if the actuarial analysis suggests these are appropriate predictors of different future costs. We may also do retrospective adjustments after people enroll. However, these retrospective adjustments will not be based on the actual service utilization during the time period the individual is enrolled in prepaid, capitated managed care. The adjustment will be based on the historical costs for the enrolled population *prior* to when they enrolled in prepaid, capitated managed care.

15. Will counties/tribes be required to include child welfare funds as part of their county share?

The DHFS has not said that these funds *must* be part of a county share. However, we did have our planning partners look at these costs as we conducted some initial analysis of the county share. Additionally:

- We know that both existing managed care programs for children with SED incorporate child welfare and juvenile justice funds into their managed care programs, and this appears to be integral to their success. This allows the MCO to have a larger pool of funds to serve these children.

- The large overlap between children with SED and children involved in child welfare and juvenile justice also suggests that it makes clinical sense to incorporate these funds into the managed care program.

- A key goal of public sector MH/AODA managed care is to take treatment funds previously locked into overly restrictive institutional placements and, instead, spend those funds more flexibly on community-based treatment. This goal applies equally to Medicaid funds spent on inpatient hospital MH/AODA treatment and to county/tribal administered funds spent on residential placements.

- Finally, including these funds is consistent with the overall project goal of integrating all public funds serving the target population. Doing so represents a significant opportunity to provide flexible, child-centered options.

16. The DHFS appears to be vague about the availability of risk-sharing for the demonstration sites.

Section V. B. (pp. 55-60) of the RFC is clear that we cannot make a definitive statement at this time and outlines the constraints the DHFS is under with regard to risk sharing. Risk sharing is possible under Family Care because the care management organization is managing only funds from the state (both Medicaid and community aids). The MH/AODA managed care MCOs will be combining the Medicaid funds with funds currently administered by the county/tribe. As a result, if the MCO loses money (if their costs exceed their revenues) it will be extremely difficult to establish whether or not that loss is attributable to Medicaid.

As noted in the RFC, one possible way around this is if the county/tribe identifies an actuarially approved amount that represents the amount of money that the county/tribe currently spends on members of the target population (from both community aids and tax levy). It may be possible, then, to develop an agreement that any loss is split between Medicaid and the county proportional to the ratio of Medicaid and county/tribal dollars funding the demonstration. For example, if Medicaid represents 40 percent of the revenue and the county share represents 60 percent of the revenue, then Medicaid would be responsible for 40 percent of losses. Note that such an arrangement would require the approval of the Health Care Financing Administration and would still be subject to the constraints identified in Section V. B. 1. of the RFC.

17. Will the county share be a fixed amount?

The DHFS and its planning partners used the term "county share" as a shorthand for the various funds that counties currently administer. However, this consists of county tax levy, state general purpose revenue and federal funds. Part of the county tax levy is a required match to the state and federal dollars and part is not. This latter is often referred to as overmatch.

As noted above, the DHFS's ability to share risk would require, at a minimum, that we establish a defined, actuarially approved amount representing the sum of non-Medicaid dollars spent per person (which would probably be county/tribal specific). However, there are also other reasons that the DHFS and counties should be interested in fixing the historical non-Medicaid cost to serve the target population:

- Our ability to determine whether the non-Medicaid costs increase or decrease under managed care requires a baseline of current costs.
- Identifying the costs to serve the target population and allocating these to the managed care program also implies that the county is leaving adequate funds on the non-capitated side to serve other individuals to the same level as they currently do.

18. Is the county or tribe's risk limited to the required county match to community aids?

No. Under the managed care contract counties/tribes will be required to provide services to meet the needs of the enrolled population. Clearly the ability of the counties/tribes to manage these funds will depend to a large degree on the ability of the Treatment and Recovery Teams to develop cost effective choices that meet the needs of the consumer.

19. Is the DHFS reluctant to engage in risk sharing because counties have been adamant about taking county overmatch off the table with regard to rate-setting for capitated programs?

No. The reasons for potentially requiring risk sharing are explained above.

The DHFS does want to include community aids in the capitation rate in the future, as is identified in Attachment 28 to the RFC. This is dependent upon collecting better data on how much of community aids is spent on the target population. We would also want to include county match as part of this capitation, but we do not know how to define this at this time. County overmatch is an important component of funding for the target population, but the DHFS is undecided at this point on the best way to incorporate this into the demonstrations in the long run. We will need more data before we can explore this with counties/tribes.

20. What percentage is allowed for overhead expenses?

If the county/tribe is at full risk, the DHFS does not dictate a percent for overhead. Overhead is assumed to be incorporated into the capitation rate in two ways:

1. The provider administrative costs are assumed to be part of the Medicaid reimbursement that forms the basis for the fee-for-service equivalent.
2. The DHFS generally adds an amount on to the capitation rate that reflects the Medicaid administrative functions that the MCO is taking on (e.g, service authorization, claims payment).

When the DHFS elects to share risk with MCOs, we do need to identify a reasonable percentage for administration before determining whether service costs exceed revenue. The proposed administrative percentages for the risk-sharing plan for Family Care are 20 percent in year one, 15 percent in year two, and 10 percent in year three.

Section VI.

21. What is the anticipated level of county resource commitment for the activities during the demonstration phase?

It is difficult for the DHFS to respond to this question. We have attempted to provide as much information as possible about our expectations in the RFC so that counties and tribes can decide for themselves what it might take to respond.

Additionally, the resource needs for any site may vary depending upon a number of factors, including:

- The adequacy of their existing information system and the types of contracting and reporting systems they currently have in place.
- The amount of network development that needs to be done, based on the range of existing provider contracts in their area.
- The degree to which sites have already developed some aspects of required programming, such as consumer-operated services or quality improvement processes.

Because there are similarities between the MH/AODA managed care demonstrations and other programs, counties/tribes may want to contact appropriate staff from these other programs to discuss these issues. These programs include Family Care, Children Come First in Dane County, and WrapAround Milwaukee in Milwaukee County.

Although this is our best response to the question at this time, we will continue to monitor the resource needs of the demonstration sites. Even though we have a defined implementation timeline we will continue to modify this as needed, as has been the case

with our planning to date to ensure that implementation can be successfully accomplished.

Section VIII

22. What is the experience/credentials of the people who will be reviewing the proposals? Will all reviewers evaluate all parts of the proposal?

The reviewers represent the various stakeholder groups that we have consistently included in our planning.

- One reviewer each from the Division of Health Care Financing and the Division of Supportive Living.
- A representative from the Wisconsin Counties Human Service Association from a county that is not submitting a proposal.
- A family member of an adult consumer.
- A family member of a child consumer.
- An adult consumer.
- Three individuals with provider level experience and expertise in different areas (e.g., mental health, substance abuse, aging).

We also have identified back-up reviewers to address any potential conflicts of interest depending upon the specific counties that submit proposals.

All of the individuals selected have had some level of involvement in the planning process to date. Minority representation is included on the panel.

All reviewers will read and evaluate all parts of the proposals. (The only exception to this will be the responses to part A in Section VIII, Leadership and Staffing. DHFS staff will evaluate this section on a pass/fail basis. DHFS staff will also ensure that all required documentation is provided prior to forwarding the proposals to our reviewers and review the project budgets for reasonableness. DHFS staff will provide instructions on evaluation criteria prior to when the reviewers receive the proposals. Reviewers will also have an opportunity to discuss discrepancies in scores after they have had an opportunity to read and evaluate the proposals.

23. Section VIII. E. 1. asks proposers to estimate the number of individuals they will enroll. Has there been any actuarial consultation as to whether there is a minimum number of enrollees that are organizationally feasible for operating a capitated managed care program?

We have not requested our actuaries to identify a minimum enrollment for a managed care program. We know that, in general, the larger the enrollment the less the risk to the managed care organization, because they can spread unexpected costs over a larger

group of people. A smaller pool of potential eligibles puts more pressure on the state and counties to be very accurate in the rate-setting process.

However, the size of the enrolled population is only one issue. Another issue that effects potential risk is the variability in the costs of the population. Where there is a great deal of variability, either for a given individual over time or across a group of individuals, it is harder to predict future costs--especially in a voluntary program.

24. Sec. VIII. L1., County Commitment, and Attachment 30 require county board action. What will happen if we are unable to get this action prior to submitting the proposal due to the scheduling of meetings and items for these meetings?

Attachment 30 does not require a county board action. It requires signature by the person authorized to make the commitments outlined in the document. Each county/tribe must determine the appropriate person to sign this document.

Sec. VIII. L1. does ask for a copy of a county board resolution authorizing the county to submit a proposal for MH/AODA managed care and to participate as a demonstration project. However, if a county or tribe has an executive officer (e.g., county executive) who is empowered to provide this authorization for the county or tribe, Sec. VIII. L1. can be satisfied through a letter from this executive officer.

If you are a county without a county executive and you have not been able to obtain the board resolution due to timing of the board meetings, need to coordinate board approval across a number of counties/tribes, or other actions of the board, please provide this information in your response. Explain fully what actions you have taken to get the board's approval, what the response has been, and when you anticipate obtaining the approval. The DHFS will waive the need to have the resolution at the time the proposal is submitted as long as we can determine that the proposer has made reasonable and prudent efforts to accomplish this and can provide a timeframe for submitting the resolution.

The DHFS will not, however, finalize a decision about awarding a demonstration site until the board resolution is submitted to the DHFS.

Addendum 1

25. Will psychiatric medications be included in the capitation rates?

All Medicaid-covered medications will be included in the capitation rate for integrated programs (those providing primary and acute care in addition to MH/AODA services). When the actuarial analysis (found in Addendum 1 to the RFC) was done, we identified the costs for drug classes generally used for treatment of psychiatric disorders in order to get an idea of the level of these costs compared to other psychiatric interventions. However, this did not reflect a decision to include psychiatric medications in the capitation rate for carve-out programs (those providing MH/AODA services only).

The DHFS recognizes the complexity of trying to carve-out psychiatric medications into a capitation rate, given the fact that many medications used for psychiatric care may also be used for non-psychiatric purposes. Additionally, pharmacy costs have been the fastest growing benefit within Medicaid and, thus, pose additional risk to potential MCOs. It is our intent to explore this area further with the successful proposers to determine whether we might want to include psychiatric medications in the capitation rate for carve-out programs. However, the DHFS will not require a demonstration site that is proposing a carve-out arrangement to include psychiatric medications in the capitation. That is, inclusion of psychiatric medication in the capitation rate for carve-out programs will be optional, but only if the DHFS determines it is feasible and appropriate to do this at all at this time.

Attachment 2

Partial List of MH/AODA ("Behavioral Health") Information Technology (IT) Company Web Sites, revised 03/23/2000

The DHFS is providing this partial list of MH/AODA information technology (IT) company web sites as a planning aid for counties and tribes preparing proposals in response to the MH/AODA Managed Care RFC. There are many different types of MH/AODA-related IT resources on this list. Some are very basic, others more complex. Some of the IT products are more compatible with recovery-oriented care, while others reflect a traditional medical model. Some are intended for specific types of treatment facilities, while others are more broadly applicable. Some of the IT products focus more on clinical issues (e.g., testing, assessment, treatment planning, outcome measurement, etc.), while others focus more on fiscal and operational issues (e.g., accounting, claims processing, capitation budgeting, provider profiling, staff scheduling, etc.) Still others are more comprehensive IT packages that integrate many of these different functions.

Disclaimer: This list is presented in alphabetical order and is not ranked in any way. The DHFS is not recommending any particular IT company or product listed here. In addition, while we expect that some or all of these web sites may provide useful information for counties or tribes doing IT planning for MH/AODA services, the DHFS does not guarantee the quality, applicability, or compatibility of any of the products listed here.

COMPANY OR IT PRODUCT NAME	INTERNET WEB SITE
ADE, Inc. –Assessment Software	http://www.adeincorp.com
Adia Information Management Corp	http://www.adiaim.com/mainpage.htm
AdvantaCare, Inc.	http://www.advantacare.com
Advantage Management & ValuSystems	http://www.web-span.com/amiteam
Access Measurement Systems, Inc.	http://www.ams-outcomes.com/index.shtml
Anasazi Software	http://www.anasazisoftware.com
Askesis Development Group, Inc.	http://www.askesis.com
Behavior Data Systems, Ltd. and Risk and Needs Assessment, Inc.	http://www.bdsltd.com
Blackberry Technologies, Inc.	http://www.blackberry.com
Behavioral Health Partners, Inc.	http://www.bhpi.com/html/menu.html
Behavioral Health Outcomes Systems, Inc.	http://www.bhos.com
BrainTrain	http://www.braintrain-online.com
CARE Computer Systems, Inc.	http://www.carecomputer.com
Civerex Integrated Software Systems	http://www.civerex.com
CMHC Systems	http://mis.cmhc.com
CNR Health (UWSI) –(Cavion™ Care Mgmt System ?)	http://cnr.uwz.com

COMPANY OR IT PRODUCT NAME	INTERNET WEB SITE
Community Care Management	http://www.commcaresys.com Note: This web site is under construction and not operational as of March 2000, but should be operational on or after April 2000.
Corporation for Standards and Outcomes	http://www.standardsandoutcomes.com
Creative Socio-Medics Corp.	http://www.csmcorp.com/index.html
Diamond Palmetto Performance Measurement System	http://www.dppms.com
Earley Corporation – Clinical Management Software for Behavioral Health	http://www.earleycorp.com
Echo Management Group	http://216.252.16.12
Health Care Software, Inc.	http://www.hcsinteractant.com
Healthcare Metrics – Performance Benchmarking	http://www.healthcaremetrics.com
InfoMC, Inc. – Health Information Systems	http://www.infomc.com
Integra Compass Suite	http://www.integra-ease.com/compass.htm
Lavender & Wyatt Systems, Inc. – HSMIS	http://209.219.18.168/LWSinew
McLean BASIS-32 Plus Performance Measurement System	http://www.mcleanhospital.org/basis32/index.htm
MediPay BehavioralCare Mgmt System	http://www.medipay.com
MentalHealth Case Manager	http://www.jobooville.com/MHCM
MentalHealth Outcomes	http://www.mhoutcomes.com
MH Corporations of America, Inc.	http://www.mhca.com/2Products.htm
MSHealth Software Corp.	http://www.mshealth.com
MSJ Corporation – SATIS © 2000	http://www.msjcorp.com/satis/index.html
NASMHPD Research Institute	http://www.nasmhpd.org/nri
OQ Systems, Inc.	http://www.oqsystems.com
JCAHO – Performance Measurement Systems	http://www.jcaho.org/perfmeas/perfmeas_frm.html
PKC Corp. – Problem Knowledge Couplers	http://www1.mhv.net/~wyee/homepkc.html
Psych Software Solutions	http://www.alinet.net/~psysoft
PsychServ by Innovative Systems Development, Inc.	http://www.psychserv.com
PsychWrite Pro software	http://www.psychwrite.com
QualityFIRST BehavioralHealth Guideline System by HRMI	http://www.hrmi.com/hds/bhgs.htm
Synergistic Office Solutions, Inc.	http://www.sosoft.com
The ClinicalManager by the MH Center of Dane County	http://www.mhcdc.org/tcm/TCMMain.html
The PsychologicalCorporation – Communication & TherapySkillBuilders	http://www.hbtpc.com/catg/nf
The Redtop Company – The Redtop Clinical Environment	http://www.redtop.com

COMPANY OR IT PRODUCT NAME	INTERNET WEB SITE
UNI/CARE Systems, Inc. –Mngd Care Software Systems	http://www.unicaresys.com
State of Wisconsin VendorNet System –as a possible source of information and/or discount purchasing	http://vendornet.state.wi.us/vendornet